Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Brian C. Buck, MD

Respondent Name
Travis County

MFDR Tracking Number
M4-14-3690-01

Carrier's Austin Representative
Box Number 38

MFDR Date Received
August 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim with this letter is for a Designated Doctors Exam. The exam included evaluations of:

- Maximum Medical Improvement
- Impairment Rating
- Extent of Injury
- Return to Work
- Other Similar Issues

Per the Texas Department of Insurance Division of Workers' Compensation Medical Fee Guideline rate for these four services comes to a total of $1,225.00 which includes:

- **$350 for an evaluation of MMI**
  *TAC Rule §134.204(j)(3)(C), regarding billing of MMI/IR evaluation states: An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be **$350**.*
- **$875 for the evaluation of three issues:**
  Return to Work, Extent of Injury and Other Similar Issues
  *§134.204(i) states that when multiple issues are addressed aside from MMI/IR, the first issue is reimbursed at **$500**, the second is reimbursed at **$250**, and the third issue is reimbursed at **$125**.*

Payment in the amount of $1100.00 has been received leaving a balance of $125.00."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 26, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2013	Designated Doctor's Exam	$125.00	$125.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursement of Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. What is the correct allowable amount for the service in question?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (i)(2) states, "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section."

   28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   The requestor billed for Extent of Injury, Return to Work, and Other Similar Issues, as required on the Request for Designated Doctor Examination (DWC032). Each of these examinations fall under section (1)(C)-(F) of 28 Texas Administrative Code §134.204 (i). The submitted documentation indicates that Return to Work was the second of these examinations billed. Therefore, the correct allowable amount is $250.00.
2. A review of the submitted documentation indicates that the requestor billed using CPT Code 99456 and modifier RE per 28 Texas Administrative Code §134.204 (k) quoted above. The required reports – Work Status Report (DWC073) and the narrative report – were also included.

   28 Texas Administrative Code §134.204 (i)(1)(E) states, "Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W8'." Submitted documentation also indicates that the requestor included modifier W8 in the billing of this code.

   The Explanation of Benefits included in the submitted documentation indicate that the insurance carrier paid $500.00 for the examination to determine Extent of Injury, $125.00 for the examination to determine the injured employee's ability to Return to Work, and $125.00 for Other Similar Issues. Therefore, the Division finds that the requestor is entitled to additional reimbursement of $125.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $125.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $125.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 19, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.